Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KYLE E JONES MD
1025 DESHONG DR
PARIS TX 75460-9330

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-1529-01

MFDR Date Received
February 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges for this claim are in accordance with Division of Worker's Compensation rule # 129.5."

Amount in Dispute: $30.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…Texas Mutual denied payment for an improperly completed form."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2012, November 20, 2012	Work Status Reports	$30.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §126.5 sets out the fee guideline procedures for work status reports.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 249 – DWC-73 NOT SUBMITTED; NOT PROPERLY COMPLETED AND/OR MISSING DOCTORS SIGNATURE; REIMBURSEMENT DENIED PER RULE 129.5
   - 248 – DWC-73 IN EXCESS OF THE FILING REQUIREMENTS. NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS. REIMBURSEMENT DENIED.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

Issues

1. Did the respondent support reason for denial?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed services as 249 – "DWC-73 NOT SUBMITTED; NOT PROPERLY COMPLETED AND/OR MISSING DOCTORS SIGNATURE; REIMBURSEMENT DENIED PER RULE 129.5" and 248 – "DWC-73 IN EXCESS OF THE FILING REQUIREMENTS. NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS. REIMBURSEMENT DENIED." 28 Texas Labor Code §129.5(h)(3)(i) states in pertinent part, "…a doctor may bill for, and a carrier shall reimburse". Review of submitted documentation finds the name listed in box 31 of medical bill lists "Donna Callicoat" whose credentials are FNP. As the Family Nurse Practitioner is listed as entity billing for the disputed services, the Division finds requirements of TAC 129.5 are not met. The carriers' denial is supported.

2. The services in dispute are not separately payable. No reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.